CAROLINA INTERNAL MEDICINE ASSOCIATES, PA
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FAX: (828)258-3390
(Please do not fax records that contain more than 50 Pages)

AUTHORIZATION AND RELEASE OF MEDICAL RECORDS

I voluntarily authorize and request: _____
_____
_____

To release medical information pertaining to:

Patient Name: _____
(Last) (First) (Middle)

Date of Birth: _____ Social Security Number:_____

____Request for Entire Medical Record
____Request for Medical Records from (Date) _____ to (Date) _____

The purpose of this request for release of information:
____Transfer of Medical Care
____Authorization to Consult
____Other_____

This information is to be released to: (Please check one)

_____ Kenneth R. Kubitschek, MD, FACP
_____ Laurie LeMauviel, DO
_____ Stephen D. Brown, MD
_____ David Clements, MD
_____ James Weaver, MD
_____ David Reilly, M.D.
_____ Mary (Blevins) Smith, MD
_____ Sarah Warren, MD
_____ Pamela B. Cavanaugh, MD
_____ James B. Hoer, MD
_____ Gaylon Owens, M.D.

_____ Amy Gibson, PA-C
_____ Catherine A. Haggart, PA-C
_____ Heather M. Hopper, PA-C
_____ Frankie Weinberger, PA-C

Note: Offices may charge a fee for record transfers. Any questions regarding this should de directed to the offices that records are being requested from by the patient.

I do hereby consent and authorize you to release copies of my personal medical record(s), by fax or mail, including current and previous medical records. Please release copies of all requested information. I hereby release Carolina Internal Medicine from liability of any nature pertaining to the release and use of said medical data or the contents thereof.

_____ _____
Signature of Patient/Legal Guardian/or Next of Kin (Indicate relationship to patient) Date of Request